

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
APPLICATION FORM FOR ENROLLMENT

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME, (LAST, FIRST, MI.):			
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	DATE OF REFERRAL:
B2H WAIVER TYPE (Check one only): <input type="checkbox"/> B2H Serious Emotional Disturbance (SED) Waiver <input type="checkbox"/> B2H Developmental Disabilities (DD) Waiver <input type="checkbox"/> B2H Medically Fragile (MedF) Waiver		APPLICATION TYPE (Check one only): <input type="checkbox"/> Initial Application <input type="checkbox"/> Re-application: completed if child's name is on the Wait List.	

INSTRUCTION: The Health Care Integration Agency (HCIA) is responsible for completing Section 1 OR 2 and returning this form within 60 days of receipt of the completed referral packet.

SECTION 1 – Child Meets Criteria	SECTION 2 – Child Fails to Meet Criteria
<input type="checkbox"/> The identified child above meets all of the eligibility criteria for participation in the B2H Medicaid Waiver Program and the following documents are attached: <ul style="list-style-type: none"> • Level of Care Form (OCFS-8005A, OMRDD HCBS Level of Care Form 02-02-97 or OCFS-8005C) completed and signed, • Individualized Health Plan (IHP) (OCFS-8017) completed and signed (<i>If budget in IHP is over \$51,600 , send a copy of IHP to Office of Children and Family Services Regional Office Quality Management Staff</i>), • Freedom of Choice Form (OCFS-8003) completed and signed, • Health Care Integrator Selection Form (OCFS-8007) completed and signed, • Waiver Participant's Rights Form (OCFS-8008) completed and signed. 	<input type="checkbox"/> The child identified above fails to qualify for the B2H Medicaid Waiver Program for the following reason(s): <i>(attach supporting documentation):</i> _____ _____ _____ _____ _____ _____

Health Care Integration Agency Information (HCIA):

HCIA REPRESENTATIVE NAME:	HCIA REPRESENTATIVE SIGNATURE: X	DATE:
HCIA NAME:	PHONE #:	
HCIA ADDRESS	CITY:	STATE: ZIP CODE:

DECISION SECTION

FOR LOCAL DEPARTMENT OF SOCIAL SERVICES (LDSS) OR DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY) USE ONLY – COMPLETE DECISION SECTION AND RETURN ORIGINAL TO HCIA

Date Received: _____ Time Received: _____ : _____ am pm

Initial Application Decision (Check one only):

- Request for B2H Medicaid Waiver Program Approved, slot available; complete Notice of Decision – Authorization, (OCFS-8009)
- Request for B2H Medicaid Waiver Program Approved, no slot available; complete Wait List Notification Form, (OCFS-8012)
- Request for B2H Medicaid Waiver Program Denied; complete Notice of Decision – Denial of Enrollment, (OCFS-8010A)

Date of Decision: _____ Time of Decision: _____ : _____ am pm

Re-Application Decision (Check one only):

- Request for B2H Medicaid Waiver Program Approved; complete Notice of Decision–Authorization, (OCFS-8009)
- Request for B2H Medicaid Waiver Program Denied; complete Notice of Decision – Denial of Enrollment, (OCFS-8010A)

Date of Decision: _____ Time of Decision: _____ : _____ am pm

CONTACT'S NAME:	CONTACT'S SIGNATURE: X	DATE:
CONTACT'S TITLE:		
CONTACT ADDRESS:	CITY:	COUNTY: STATE: ZIP CODE:

Original – Health Care Integration Agency; **Copy of Completed 8004 Form Only** – Child/Medical Consenter, Case Planning Agency, Caregiver, OCFS Regional Quality Management Specialist; **Copy of 8004 and Supporting Documentation** – Local Department of Social Services or Division of Juvenile Justice and Opportunities for Youth